CENTRAL STATE HOSPITAL
PETERSBURG, VIRGINIA

SNAPSHOT INSPECTION
AUGUST 10, 1999

OFFICE OF THE INSPECTOR GENERAL

Facility: Central State Hospital

Type of Inspection: Snapshot, unannounced. Secondary Inspection follow-up from original Secondary Inspection of 6-18-99.

Date: August 10, 1999

Purpose of Inspection: 1) Inspect Staffing Pattern and General Activities of Patients in Admission Units, Building 93, 2) Follow-up on progress made toward implementing initiatives relating to the Critical Incident occurring June 13, 1999.

Section One

Snapshot Inspection Building 93

1.1 Finding: Four staff were present on two of the three Units in Building 93. RN staffing met the recommended 1 FTE per unit for this shift.

Background: Administrative staff has made the decision to have four staff present on all shifts in Building 93 at all times. Census and staff break down as follows on August 10, 1999, second shift:

Building RN Supervisor: 1 Registered Nurse

Ward 1: 17 Male Patients

1 Registered Nurse (RN)
1 Licensed Practical Nurse (LPN)
2 Mental Health Technicians (MHT)

Ward 2: 10 Female Patients

1 RN
2 MHT

Ward 4: 15 Male Patients

1 RN
4 MHT (one of these was assigned to 1:1 duty)

Recommendation: Continue to prioritize appropriate staffing of this critical unit.

1.2 Finding: None of the staff present this shift were mandated to stay over from the previous (day) shift.

Background: Mandatory stay over has been a significant problem in this building over the summer. Things seemed improved since the last snapshot inspection of six weeks ago, but still are not optimal. At least two staff were required to stay over from night shift 8-9-99 to day shift 8-10-99. As of 6:00pm, only one RN was confirmed for the night shift on 8-10-99, three LPN's were scheduled for this shift.

Staff present did express the idea that things had improved over the last six weeks with regard to staffing. The principal reason for this is a decrease in 1:1 monitoring. Tonight there was only one patient requiring 1:1 in the building. Several weeks ago there were as many as six or more patients requiring 1:1 monitoring. This included several patients at acute medical hospitals as well as Building 93 with 1:1 requirements for psychiatric instability. By line staff impression, new admissions over the last several weeks were less medically ill. There has been some overall reduction in the census of the building, with a target of no more than 15 patients per unit.

Recommendation: Continue to work on staffing this critical building.

1.3 Finding: The general environment was quiet and orderly on each of the units this evening.

Background: There has been a reduction in census, particularly on the female admission unit, Unit 2. The commitment to maintain no more than 15 patients per unit has been reinforced. The patients were generally clean, quiet and comfortable. There was a sense of peace on the units that was not there on the previous snapshot inspection, July 1, 1999.

Recommendation: Maintain commitment to cap census at fifteen per admission unit.

Section Two
Follow-up of Critical Incident Originating June 13, 1999.

2.1 Finding: The root cause analysis has been completed and submitted to JCAHO on time.

Background: This document was prepared by a group of staff on a special committee. The committee met one or more times a week for the last five weeks preparing this document. Committee members felt the process was exhaustive and complete. There were varying opinions regarding the extent to which the content of the document itself was effected by fear that this document may become public. Irrespective of the content, the committee felt the process of self-scrutiny was helpful. Given this, the document appears adequate, and does spell out plans to address circumstances that may have contributed to the tragedy occurring June 13. Because the process of preparing the Root Cause Analysis document is valuable, it is advisable to have staff as close to the event as possible involved. Neither the attending psychiatrist nor direct care nursing staff from the unit was part of the actual committee preparing the report. The committee solicited their input. No outside person participated in the process. It may be helpful to have a "consultant" such as risk management from DMHMRSAS or a sister facility professional peer participate on the committee.

The report is probably more polished than it would be in ordinary times, however these are not ordinary times for CSH. Based on my discussions with committee members, the process of self-scrutiny occurred and was educational for staff on the committee.

Recommendation: Do not lose sight of the purpose of a Root Cause Analysis. The staff closest to the sentinal event should benefit from the self-scrutiny process.

2.2 Finding: All of the staff present on Ward 4 the night this event occurred continues to perform direct care.

Background: As of this date, no disciplinary action has been taken against any staff. This is still under consideration. This is a particularly difficult situation. Many of the nursing staff I informally spoke with today and on other visits relates that there has been a clear-cut pattern of "scapegoating" staff when something goes wrong. There is the sentiment that when something goes wrong, the first response is a "witch-hunt" for the staff that did something wrong rather than solving underlying resource problems and supporting staff through education, supervision, peer

review, etc. With regard to the management of the aftermath of this particular event, the administrators I have spoken with seem very aware of this "scapegoating" reputation. They are proceeding very cautiously in part because of the risk of worsening morale. As supervisors, it is their responsibility to identify problems with performance and professional judgment that may have been related to this tragic event. We owe this to staff, but most of all to the patients staff are responsible for.

Recommendation: None immediate. The decisions management makes will be revisited in future inspections.

2.3 Finding: Teams have been shifted such that there is one team per unit.

Background: Previously units had patients on more than one team. Although this might be seen in a private hospital with multiple attending physicians, this arrangement is not optimal for the severe and persistently ill patient population served in a public facility. Communication within a unit and team is critical. This was planned for some time, but implemented in an expedited fashion as a result of this critical incident. The new nursing director also has developed plans to fortify the unit team concept by developing a Unit Chief Nurse. This nurse will be present usually on day shift, but will staff all three shifts. This should develop and promote better communication within a given unit. Unfortunately this is yet another change for staff to endure, but it is an idea with great promise.

Recommendation: Administration may want to look at ways to support the unit team concept. One idea may be to have administration meet briefly with each of the unit teams in Building 93 several weeks after the establishment of the new arrangement to informally assess effects on facilitating patient care.

2.4 Finding: Patients have not been reassigned based on acuity.

Background: Based on administrative analysis of a problem occurring several months ago, administration decided to rearrange patients on the two male admitting units. There has been some family resistance to this occurring. This was supposed to have been done by September 1, 1999. The Risk Management Panel will be following progress toward this goal. Patients have not been moved. It was not clear as to whether existing patients would be rearranged, or this might be addressed with new admission ward assignments over time.

Recommendation: Moving of any existing patients should be done with patient consent and cooperation so that it disrupts their lives as little as possible. Maybe this idea could be approached over time without moving existing patients.

2.5 Finding: In-service training on Communication and Documentation is well under way throughout all three units in Building 93, the admissions building.

Background: Per Administrative analysis of the factors contributing to the unfortunate event, it was determined that an inservice on communication expectations between levels of staff as well as documentation of significant events should be developed. This has been done by Marcia Adams RN, the Chief Nurse of the Civil Admissions Unit. She has presented these two sessions to most of third shift and will be working with day and the remainder of night shift over the next several weeks. Suggestion was made that she may also want to develop some information on risk assessment for the RN level staff in her building. Communication is a priority of the new CSH Director of Nursing, Isaac Abraham.

Recommendation: Continue to develop and enhance communication lines among staff in admissions and throughout the facility.

2.6 Finding: An allegation of neglect was made against one staff relating to the incident occurring June 13, 1999.

Background: This situation was investigated and the allegation of neglect was determined to be unfounded. Currently individuals employed by the facility do abuse and neglect investigations within facilities. A report is presented to the facility Director who is responsible for making the determination. The patient can appeal the decision. Concerns have been raised regarding the true ability of an investigator to be independent under these conditions. CSH is unusual in that it has a full time investigator with a background in both the criminal justice system and the armed forces.

Recommendation: None immediate. Central Office may want to focus on enhancing the independence of these investigators.